ADAA Management Conference 2003

By Sue Roberson

This year's management conference was held on October 14th and 15th at Rocky Gap Lodge and Resort, located in scenic Western Maryland. Approximately 150 Prevention Coordinators, County Addiction Coordinators and ADAA-funded treatment program directors attended the conference. The conference theme was program performance, and featured Dr. Dwayne Simpson, Texas Christian University- Institute of Behavioral Research; Dr. Raye Z. Litten, Division of Treatment and Recovery Research, National Institute on Alcohol Abuse and Alcoholism (NIAAA); and Dr. Maxine Stitzer, Johns Hopkins University and the National Institute on Drug Abuse (NIDA)- Clinical Trials Network. Dr. Peter Luongo, the Director of the Maryland Alcohol and Drug Abuse Administration opened the conference with an address that emphasized elements of effective program performance. On the second day of the conference Dr. Luongo presented to participants his vision of the "Interfaith Marriage of Prevention and Treatment" (see the Director's Corner page 3). Attendees had an opportunity to share their thoughts, questions and concerns during a question and answer session with the Director.

Keynote speaker Dr. Dwayne Simpson identified factors affecting patient retention in treatment and described an evidence-based treatment model, linking research proven interventions to each stage of treatment. After identifying points at which treatment can be improved, he discussed the process of adopting changes to support improved program performance. Dr. Simpson emphasized the importance of assessing program readiness for change.

Both Dr. Litten and Dr. Stitzer presented recent research findings. Dr. Litten emphasized encouraging studies on the use of medications to treat alcoholism. Dr. Stitzer focused on research conducted by the NIDA Clinical Trials Network, highlighting her research study on "Motivational Incentives for Enhanced Drug Abuse Recovery."

Afternoon workshops supported the program performance theme, offering participants the choice of grantwriting techniques, regulatory issues, a showcase of successful program practices, using data to measure performance, leadership skills and a strategic planning simulation game (Friday Night in the E.R.).

Conference Internet Resources

Dr. Dwayne Simpson - Institute of Behavioral Research at Texas Christian University;
http://www.ibr.tcu.edu

Bureau of Governmental Research - HATS Tip Sheets;
http://www.bgr.umd.edu/hats_tips.html

Dr. Raye Z. Litten – National Institute on Alcohol Abuse and Alcoholism;
http://www.niaaa.nih.gov

Dr. Maxine Stitzer - National Insititute on Drug Abuse/Clinical Trials Network;
http://www.nida.nih.gov/CTN/.Index.htm

Many of the Keynote and Workshop PowerPoint presentations are available on the ADAA Web site;
www.maryland-adaa.org

Management Conference 2003

....*Your Comments*

"The HATS update and COMAR discussion were most helpful."

"I thought the workshops were on target and well-planned."

"The workshop on leadership was excellent."

"The grantwriting workshop was very informative."

"Wide array of workshops; would have liked to have had time to attend more of the workshops."

"Friday Night in the E.R... a great experience"

"Keynote and Plenary speakers kept my interest and were motivating."

"Keep up the vision"

"Very, very well done, professional agenda, benefical and timely."

"Dr. Luongo's presentation on blending prevention, intervention and treatment was most useful."

"Great opportunity to network and build resource pool."

"Relaxing atmosphere, well planned, relevant and topical."

"Consider re-working the agenda so that we can enjoy the setting more ."

"We need another day to network."

"An opportunity for prevention and treatment professionals to meet and train together."

"It was an opportunity to collaborate and hear about how others are dealing with challenges."

From the field.....

This editions's field author is Jim Brenneman. Jim writes about his experience implementing quality improvement measures to enhance program performance.

Providing high-quality services is a worthy goal for treatment providers. The degree to which we achieve this goal is impacted by many variables. Three I think important are:

- top-level management commitment to quality improvement
- openness to criticism
- willingness to change

Management commitment can probably best be demonstrated by a willingness to allocate resources (often time) to improvement. Too often we are so busy "putting out fires" that we do not take time to look for ways to systematically improve. Whether as individuals or as programs, improvement comes as a result of identifying areas in which we do not measure up to our aspirations. This is an uncomfortable process and may be so much so that we close our programs to criticism. Being willing to change is often not as easy as it sounds. Many times we have cherished notions of "how things should be" that are not grounded in data.

The name you give your quality program and the particular techniques you use are probably less important than the three variables I have listed above. Whether you are using QA, TQM, CQI, or something else, the general goal of finding better ways to deliver services that are timely, cost-effective, provided humanely, and produce the desired outcomes does not change.

Having said this, it is useful for managers to educate themselves about various techniques and tools that assist in identifying opportunities and achieving improvement. Several principles I have found useful include:

- have a wide range of methods for identifying improvement opportunities
- ensure your efforts are driven by data
- focus first on processes, systems and organizational norms - not on individuals

Among others, my program uses regular management reports, SAMIS data, suggestion boxes, staff meetings, client surveys, external customer (i.e. Drinking Drivier Monitor Program, Public Defender, etc.) surveys, and an annual staff retreat to identify improvement opportunities. However, before we devote significant resources to improvement based on someone's "good idea", we work to ensure that it really is an area in need of improvement, by collecting and analyzing data on the issue.

Finally, focusing first on your system involves adopting the attitude that most of your staff, most of the time, want to do good work. As managers, too often we automatically assume that a lack of quality can be traced back to a "problem employee". Often it is the system or organizational expectations that are the root of the problem and prevent staff from doing their best, rather than a lack of motivation.

As an example, a concern expressed in our outpatient staff meeting a number of years ago was that the time between completion of the psychosocial assessment and the next face-to-face clinical contact was too long. Subsequent evaluation of data revealed that the average time was 12.14 working days. Believing this was too long, my first (unstated) reaction was to blame the clinical staff (they don't care, they are lazy, etc.). However, assessment of the process using a flow chart revealed that the main problem was the amount of time it took to assign the client to a clinician following assessment. Correcting the process flaws resulted in the average time being reduced to 4.71 working days.

Jim Brenneman is the Director of the Outpatient Addiction Program at the Allegany County Health Department.

SYNAR 2003

Maryland retailers refused 90 percent of tobacco sales to minors in random, unannounced investigations last year. This is a 16 percentage point increase since 2001 and a 40 percent increase since the survey was implemented in 1997.

Research shows that most smokers began the habit by the age of 18. It is estimated that approximately 3000 teens become hooked on nicotine each day. In 1992, Congress enacted the Synar Amendment to reduce the sale of tobacco products to minors. Maryland has repeatedly met that challenge. Last year's non-compliance rate was 10.8 percent. This rate continues a downward trend from the 1997 rate (36.1 percent) and represents a sharp drop from the 2001 rate of 25 percent.

Increased retailer education and prevention efforts by the Maryland Department of Health and Mental Hygiene, frequent investigations by the ADAA Tobacco Compliance Unit, and national prevention efforts are likely reasons for the increased compliance. Maryland has stepped up its efforts considerably since 1997. In 2002, Maryland allotted $9,219,674 to tobacco education and prevention efforts.

A complete copy of the 2002 Maryland Synar Report can be found on our Web site at www. maryland-adaa.org

Recovery Month Kick-Off A Big Success

By Carol Ann Michalik

On September 5th, ADAA celebrated National Alcohol and Drug Addiction Recovery Month by hosting a concert and health festival on the ADAA grounds in Catonsville. This year's theme, "Join the Voices for Recovery: Celebrating Health," called attention to co-occurring mental health disorders and co-existing physical conditions that further complicate addiction treatment and recovery. In the spirit of that theme, ADAA partnered with the Mental Hygiene Administration (MHA) to raise awareness and celebrate the effectiveness of people who dedicate their lives to the treatment field.

Nelson J. Sabatini, Secretary of the Maryland Department of Health and Mental Hygiene, spoke on behalf of Governor Robert L. Ehrlich. Secretary Sabatini stressed the governor's commitment to substance abuse treatment, describing this administration's intention to make treatment issues a priority in the coming year. Keynote speaker Lewis Gallant, Executive Director of National Association of State Alcohol and Drug Abuse Directors Inc. (NASADAD), spoke about the importance of a state/federal partnership in advancing the cause of recovery. Maryland Delegate Shirley Nathan-Pulliam, a known substance abuse and mental health advocate, shared her personal experience as the mother of an addicted son.

Recovery Month was established by the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT), to promote substance abuse treatment and recovery and to educate the public that addiction is a chronic, but treatable, public health problem that affects us all. Recovery month celebrates the successes of individuals who have engaged in treatment and recognizes individuals who have dedicated their lives to helping those in need.

Approximately 45 treatment programs and community organizations participated in the health fair. Visitors listened to live entertainment while viewing information displays. Singer and puppeteer Jack Foreaker of Haven House and The Spring Grove Band were among the performers who entertained the crowd.

ADAA will continue to recognize National Recovery Month with an annual event to be held each September. Look for details in the coming months.

Leadership continued from page 3.

Encouraging the Heart involves: **Recognizing Contributions *and* Celebrating Accomplishments**

These are the five practices that Kouzes and Posner's (2002) research studies have identified as the most important elements of effective leadership. The challenge to leaders, then, is to courageously assess themselves in these practices and make plans for improving in the areas in which they need improvement. Are you, as a leader, ready to take on this challenge? Hopefully so, for your success and the success of your organization, fully depend upon it. My best wishes to you in accepting this challenge.

References

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Sanctioned Programs In Maryland as of October, 2003

RIGHT TURN OF MARYLAND

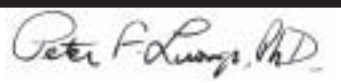
Settlement Agreement 10/20/03 - 6/30/04

General Certification of Approval

Registration No. 6026

That Question?

Director's Corner



At a recent Health and Human Services Sub - Committee hearing of the Maryland Senate Budget and Taxation Committee, a perceptive Senator posed the question; " If we are doing so well with treatment, why are there still so many addicts?"

That was not the first time the question has come up. And it probably shouldn't be the last.

The question highlights the fact that the strategy to deal with the number of addicts has consisted solely of trying to boost treatment capacity. This *has* resulted in capacity increases and an increase in the number of individuals treated. It has not reduced the number of addicts in the state. You might speculate that there hasn't been sufficient capacity expansion. Point taken. But how much (and what type) is sufficient has been poorly chronicled, and is part of the field's ongoing frustration. You might speculate further, that treatment is ineffective. That doesn't appear to be the case. When individuals enter and engage in treatment they experience decreases in substance use, increases in employment and decreases in criminal behavior.[1] All desired outcomes. No, the explanation lies elsewhere. It may include the fact that there is insufficient capacity, but that doesn't explain it all. In other words, whatever we are doing, the indoctrination of *new* individuals to addiction does not appear to be dampened. Until it is, the number of addicts will not appreciably decrease.

At the 2003 ADAA Management Conference a plenary session was devoted to, "Interfaith Marriage: Prevention and Treatment." The discussion centered on the artificial and unproductive delineation between prevention and treatment. Herein may lie a better understanding of why treatment alone cannot reduce the number of addicted individuals. The developing science of prevention research has produced some useful findings. These include an understanding of risk and protective factors and the development and dissemination of evidence-based programs with standardized, manual guided interventions. Why shouldn't this information, joined with what we know about treatment, be useful in reducing the number of addicted individuals? It should be.

A modest proposal is to align prevention, (and intervention) and treatment as a functional entity. Design these components as interdependent. Plan on the end as a reduction in the number of addicted individuals in the community. Try selected prevention interventions with groups known to be at the highest risk of developing an addictive disorder, e.g. children whose parents are in treatment or incarcerated. Have family focused treatment that includes prevention specialists working with parents, children and extended family. Derail the next generation of addicts by working with those known to be at highest risk.

None of this is new thinking. None of this requires funding initiatives. It requires working differently. That question won't go away.

(Footnotes)

[1] See, *2002 Outlook and Outcomes,* and *TOPPS II*

2002 Outlook and Outcomes[1], is the annual publication of the Alcohol and Drug Abuse Administration (ADAA). Former ally two publications (Trends and Patterns and The Annual Report) it presents data from the Substance Abuse Management Information System (SAMIS) to which all Maryland Department of Health and Mental Hygiene (DHMH) certified or Joint Commission on Accreditation of Healthcare Organizations (JCAHO) are required to report. ADAA Publication No. 03-2-001, August 2003.

TOPPS-II is the Treatment Outcome Performance Pilot Studies Enhancement that was funded by contract UR1TI11639 from the Center for Substance Abuse Treatment of the Substance Abuse and Mental Health Services Administration, US Department of Health and Human Services to the Maryland Alcohol and Drug Abuse Administration. William Rusinko was the Principal Investigator on the project from the ADAA. The study was conducted by the Center for Substance Abuse Research (CESAR), University of Maryland, College Park.

The Open Society Institute-Baltimore Drug Addiction Treatment Program and The Johns Hopkins School of Public Health

Present

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Dr. Nancy Hoffman on Leadership Skills

Nancy Hoffman, Ph.D., is the Interim Chief of the Training Services Division for the Department of Health and Mental Hygiene. Dr. Hoffman is an Adjunct Faculty member at Towson University where she teaches courses such as "Work Groups in Organizations", "Team Building" and Wellness in the Workplace."

"Leadership," according to Webster's, is "the ability to direct, command, or guide a group or activity." (Agnes & Sparks, 1998) Few people would question this definition. The age-old debate, however, has been around whether leaders are born or made. I would argue both are true. Certainly some people appear to have been born with a natural talent for influencing others. The good news for those individuals who aspire to be leaders but were not born with this innate talent is that research has shown there are some very discrete skills that may be learned in this area. (Hogan, Curphy & Hogan, 1994)

So, what are these skills and behaviors that typify good leadership? They have changed much over the course of history. According to one of the very early thinkers on this topic, "We have not seen great things done in our time except by those who have been considered mean; the rest have failed." (Machiavelli Quotes, 2003) This approach was softened, but still somewhat apparent in our country's initial research and writings on the topic of how to effectively lead people. For many years, the belief was that the good leader needed to use command and control tactics to get the people to do what was desired. This may have been effective in a simpler time. But today's world is changing in an increasingly unpredictable manner and at an extremely rapid pace. Wise leaders in all fields have recognized that they must look for new approaches to getting work accomplished through people. (McMillan & Nickol, 1995) Many years of research have helped clarify the behaviors and skills that are needed by today's leaders. While this research has resulted in numerous leadership models, most are very similar in the approach outlined. Let me present one of the recent models that I find particularly useful.

In their book, "The Leadership Challenge: How to Get Extraordinary Things Done in Organizations," (2002), James Kouzes and Barry Posner describe a leadership model based on numerous research studies which they have conducted. They approach leadership as an observable, learnable set of practices. Anyone, they say, who has the desire and persistence and is given the opportunity for feedback and practice can substantially improve their leadership abilities. Let us take a look at these practice areas.

Challenging the Process – According to Kouzes and Posner (2002), leaders need to learn to innovate, experiment and be on a never-ending search to find ways to improve the organization. They need to be fearless risk-takers who treat mistakes as learning experiences. True leaders, they say, are pioneers who constantly seek to change the status quo.

This practice of Challenging the Process involves: **Searching for Opportunities *and* Experimenting and Taking Risk**s

Inspiring a Shared Vision – Leaders must keep their eyes on the horizon and beyond. Not only do they need to be able to envision the future with a positive and hopeful outlook, but they must be able to effectively communicate that vision throughout the rest of the organization. By being expressive and genuine, good leaders attract followers and are able to show them how mutual interest may be met through commitment to a common purpose.

Inspiring a Shared Vision involves: **Envisioning the Future *and* Enlisting the Support of Others**

Enabling Others to Act – Good leadership is about relationships built on mutual trust. They emphasize collaborative goals and actively involve others in planning. By giving their employees discretion to make their own decisions, effective leaders ensure that people feel strong and capable.

Enabling Others to Act involves: **Fostering Collaboration *and* Strengthening Others**

Modeling the Way – Leaders are clear about their business values and beliefs and behave consistently with these values. As such, they provide role models for how others in the organization are expected to act. Leaders also create opportunities for people to succeed by breaking down projects into achievable steps. As they focus on key priorities themselves, they make it easier for others to achieve goals.

Modeling the Way involves: **Setting an Example *and* Planning Small Wins**

Encouraging the Heart – Effective leaders encourage people to persist in their efforts by linking recognition with accomplishments. They express pride and appreciation for their team's accomplishments. By nurturing team spirit, they enable people to sustain continued efforts.

(Continued on page 6)

What the Data Say…..

Factors Associated with Retention in Treatment

By Bill Rusinko

> **What the Data Say....**
>
> is a regular Compass Newsletter column written by ADAA's Research Director, Bill Rusinko. Bill welcomes feedback from the field on the cause and effect factors related to the research.
>
> *Share your thoughts and comments with Bill. Call 410-402-8661, or email; rusinkow@dhmh.state.md.us.*

In the FY 2004 ADAA grant submission process, jurisdictions were expected to review performance on retaining patients and set goals to keep patients in treatment for at least 90 days. The "Outlook and Outcomes 2002 Annual Report" clearly demonstrates that length of time in treatment is significantly associated with positive patient outcomes.

Results show that the percentage of patients using their primary drug of choice is higher at discharge (than at admission) until 90 days of treatment have elapsed. For those staying longer, the percentage using is dramatically reduced. Obviously, if patients can be influenced to stay in treatment longer we can anticipate their outcomes will be better. An important question is: What are the admission characteristics of patients who tend to remain in treatment longer?

During FY 2002, 65 percent of outpatient admissions were retained in treatment at least 90 days. In general, criminal justice referrals were retained significantly longer than voluntary referrals, no doubt related to the threat of incarceration. Seventy percent of FY 2003 criminal justice referrals stayed longer than 90 days. Interestingly, patients with one prior arrest had higher retention rates than those with either none or two or more arrests in both years. These may be patients whose completion of treatment will ameliorate legal difficulties.

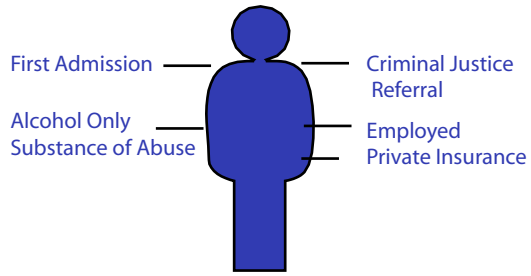
Not surprisingly, employment was highly associated with retention. Seventy two percent of FY 2003 employed patients stayed at least 90 days. In FY 2003, as prior admissions ranged from zero to five or more, retention rates ranged from 68 to 52 percent. Correspondingly, first admissions to programs had higher retention rates than readmissions. Clearly, patients with multiple treatment failures will need reinforced efforts to keep them engaged in the treatment process.

Privately-insured patients had higher retention rates compared to other health coverage categories such as Medicaid and Medicare. Patients with mental health problems were less likely to engage in 90 or more days of treatment, as were smokers and the homeless.

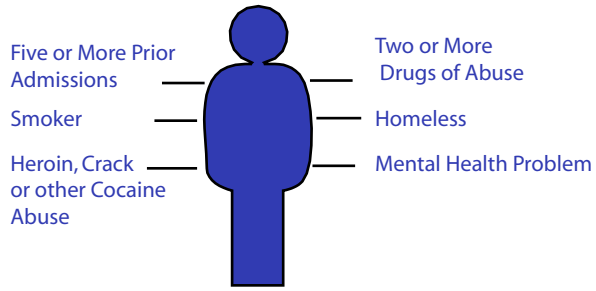
By far, patients who reported only alcohol problems had the highest retention rates – 77 percent. The number of substance problems per patient was inversely related to the retention rates. The major substances with the lowest retention rates in FY 2003 were inhaled heroin (40 percent), injected heroin (47 percent), non-prescription methadone (44 percent), other opiates and synthetics (54 percent), crack (50 percent), other cocaine (54 percent), and methamphetamines (51 percent).

The intent of this data overview is to assist clinicans with identifing characteristics of patients at increased risk for early departure from treatment. For further information on treatment retention risk factors read "Outlook and Outcomes 2002 Annual Report", which can be found on the ADAA Web site at; www-maryland-adaa.org

Factors Associated with Increased Percentages of Treatment Retention Beyond 90 Days



Factors Associated with Decreased Percentages of Treatment Retention Beyond 90 Days



DHMH-ADAA
55 Wade Avenue
Catonsville, MD 21228
Phone: 410-402-8600 Fax: 410-402-8601
E-mail: dgreen@dhmh.state.md.us

We are on the Web
www.maryland-adaa.org

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COMPASS

A Quarterly Newsletter for Maryland Addition Treatment and Prevention Providers and Stakeholders

October 2003

In This Issue

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ADAA Information Services
55 Wade Avenue
Catonsville, MD 21228

Debbie Green, Webmaster/Publisher	410-402-8592	dgreen@dhmh.state.md.us
Cindy Shupe, Director Info. Services	410-402-8591	shupel@dhmh.state.md.us